Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN5445PCA	A. BUILDING _____ B. WING _____	04/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL VALLEY HOME HEALTH CARE	368 GRANT DR STE A RENO, NV 89509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	Initial Comments This Statement of Deficiencies was generated as a result of the initial State Licensure survey conducted in your facility on April 28, 2009. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. These findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The agency had applied for a license as a Personal Care Aide Agency which provides in-home personal care services to elderly and disabled persons. The census was 48 clients. Nine client charts were reviewed. Nine employee files were reviewed. There were no complaints investigated. The agency was found in substantial compliance. No further action is necessary concerning this statement of deficiencies. Please retain this copy for your records.	P 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE